Gallery57

patient registration

Last Name ______________________ First Name ______________________ Middle Initial ________

Birth Date ______________________ Preferred Name ______________________

Salutation: Mr. Mrs. Ms. Dr. Marital Status: Single Married Partnered Widowed Divorced

Street Address ______________________ Apt.___ City____________ State ______ Zip ______

Home Telephone ______________________ Work Telephone ______________________ ext. ____________

Mobile ______________________ e-mail ______________________

How would you prefer to be contacted? Home tel. Work tel. Cell e-mail

Do you have a preferred appointment time (day and/or time)? ______________________

Emergency Contact ______________________ Phone ______________________

Whom may we thank for referring you? ______________________

Do we treat any other members of your family? ______________________

The purpose of my visit is ______________________

If you have dental benefits and would like us to generate a form for you, please provide the following information.

Employer ______________________ Address ______________________

Insurance Company ______________________ Address ______________________

Policy Number ______________________ Social Security Number ______________________

If you have dental benefits through a family member and would like us to generate a form for you, please provide the following information.

Name of Insured: Last ______________ First ______________ Middle Initial ________

Relationship to insured ______________ Policy Number ______________

S.S. Number of Insured ______________ S.S. Number of Patient ______________

Employer ______________________ Address ______________________

Insurance Company ______________________ Address ______________________

If patient is a minor or someone other than the patient if responsible for the account, please provide the following information.

Name of Responsible Party ______________________ Relationship ____________ Tel. ____________

Street Address ______________________ Apt.___ City____________ State ______ Zip ______

Signature of guardian (for patients under eighteen) ______________________ Date ____________

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT

Date ______________ Signature ______________________